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13. ABSTRACT *(Maximum 200 Words)*

Prostate cancer disproportionately impacts African American men. Disparity in rates of morbidity and mortality demand focused attention on the problem. Churches have been identified as a mechanism for delivering prostate cancer messages. Traditionally, little account has been taken of the variations between church denominations. It is the objective of this research to explore denominational differences that may influence implementation of prostate cancer education programs. A total of 357 pastors across Baptist, Seventh-day Adventist, Presbyterian and Church of God in Christ denominations completed a 30-item survey. The survey assessed church and pastoral demographics, church health ministries, church resource needs for health programs, denominational beliefs and prostate cancer-specific beliefs. There was a high level of interest in bringing prostate cancer programs into the churches and in having tailored material. Difference by denomination with respect to beliefs and awareness about prostate cancer were minimal. Participatory research with faith-based populations requires considerable time to cultivate and knowledge of these organizational structures is critical to undertaking this type of research project.

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INTRODUCTION

The goal of the research is to explore denominational differences in doctrine related to preventive health, specifically, prostate cancer, and to determine the capacity of churches to engage in prostate health promotion. The proposed research is being conducted in three phases: Phase 1 included selection of four predominantly African American denominations to participate in the research, formation of a steering committee to guide the research activities and the completion of in-depth interview with ministers from each of the denominations. In Phase 2, a mail survey was sent to ministers to assess the current prostate cancer-related activities engaged in by the ministers and their churches, and the acceptability of a wide range of activities and prostate cancer messages/materials that might be integrated into sermons or other channels of communication. Additional methods were employed to increase the number of completed surveys. During Phase 3, information from the survey analysis informed the creation of prostate cancer education resource packets for each of the denominations. Those packets are in the process of being mailed.

BODY

I. Status of the Statement of Work

This section lists each task outlined in the approved Statement of Work and provides a detailed summary of each of the activities for years two and three of the grant. Tasks 1-4 were submitted and completed in prior reports. Tasks 5-7 have been completed and Task 8 is near completion. Tasks 5-8 are submitted for the first time as part of this report. The task numbers refer to those indicated in the original research proposal. Only appendices associated with Tasks 5-8 are included in this report.

Task 1. Convene First Meeting of the Steering Committee

A. Denomination selection occurred for three denominations: Seventh Day Adventist (SDA), Presbyterian, and Baptist in Year 1 of the grant. After much effort, a fourth denomination, Church of God in Christ (COGIC), joined the study in Year 2. A representative of COGIC, though not a minister, served on the Steering Committee.

B. Representatives from each of the three denominations served as members of the Steering Committee. Dr. DeWitt Williams is the SDA representative, Dr. Curtis Jones is the representative for the Black Presbyterian Caucus (BPC), and Reverend Cessar Scott is the representative for the Baptist General Convention (BGC) of Virginia. Each representative holds a position at an executive level within his respective denomination. Additional members of the steering committee include faculty, a urology oncologist, consultants, and a lay person.

C. The first steering committee was held on October 28, 1998 with all but two members present. Additional meetings were held between the PI and staff with various members of

the steering committee and consultants.

Task 2. Collect Relevant Doctrine

A. Each of the ministers represented on the steering committee provided documents that pertain to doctrinal teaching as well as health materials used and/or developed by the denomination. An example of two of these documents are the SDA's "Ministries of Health and Healing: A Handbook for Health Ministries, Leaders, Educators and Professionals" and the Presbyterian's "Book of Order 1998-99: The Constitution of the Presbyterian Church (U.S.A.) Part II." With the exception of the SDA text, there has been a dearth of materials collected during the in-depth interviews particularly relevant to the study.

B. Several ministers interviewed during Phase 1 requested materials on prostate cancer. In response to these requests, materials were obtained from the John Hopkins Cancer Information Service (CIS) coordinator and made available to the requesting pastors. A goal of Phase 3 is to make tailored materials available to each of the participating denominations.

C. Based on the limited materials provided and described in the two preceding paragraphs, reliance on selection of doctrine relevant to health and health behavior was reviewed and analyzed from the data collected during Phase 1 qualitative interviews with ministers. A preliminary review of the items that correspond to doctrine and health indicated a shared scriptural basis for the denominations' views regarding health. However, the SDA denomination is unique in that its doctrinal teaching is both health oriented and health practiced and as such, guidelines exist for its clergy and members to carry out these principles. The collection of relevant doctrine and related material was an ongoing effort throughout all phases of the study and included literature from national organizations such as the National Council of Churches, American Cancer Society (ACS), National Cancer Institute (NCI), CIS, and prostate cancer support groups and advocacy organizations such as "Us Too" and "Brother to Brother."

Task 3: Conduct In-depth Interviews with 32 ministers

A. During the first steering committee meeting, Dr. Curbow (Investigator) led the committee through the process of identifying criteria for selection of churches and pastors for the in-depth interviews in Phase 1 of the study. Included in the criteria were factors such as 1) church size – small, medium or large; 2) church location -- rural, urban or inner city, or suburban; 3) geographic placement of the church – east, west, north, and south; 4) gender of the pastor; 4) age of the pastor; and 5) years as pastor of the church. Each steering committee ministerial representative was provided the criteria to guide his nomination of potential ministers to be interviewed. Subsequent to the meeting, the Johns Hopkins University (JHU) research team met and began to draft items for the in-depth interviews.

Several drafts were distributed among the steering committee until a final version was accepted.

B. Each of the ministerial representatives was asked to submit 10 to 12 names of pastors, home and church addresses, approximate size of each church's congregation, and type of setting of the church's location . Not all of the information was supplied completely and submission, in some cases, took longer than expected. Through the interviews, we would be able to verify and/or obtain information on these demographic characteristics that may have been unavailable to the ministerial representative. The list of Presbyterian ministers was generated through the Principal Investigator's attendance at a national Black Presbyterian Clergy Conference in St. Louis, Missouri in April, 1999. Steering committee ministerial representative, Dr. Curtis Jones, President of the Caucus of Black Presbyterian Clergy, invited the PI to attend and deliver a presentation on the research study.

C. Approval was granted by the Army Medical Research and Materiel Command and the JHU Committee on Human Research (CHR) for all phases of the study and supporting documents.

D. The original count of 32 ministers was changed to 24 (8 per denomination) since a fourth denomination has not been chosen. A total of 36 ministers' names comprised the list used to generate in-depth interviews. Letters were mailed to all of the names provided and none were returned. Approximately 3 to 4 weeks later a second priority reminder mail letter was sent to those who had not been contacted or scheduled for an interview.

E. A total of 20 interviews were completed. The period of time to complete Phase 1 interviews took considerably longer than was anticipated. The primary reason can be attributed to the number of attempts required to make contact and schedule an hour long interview (approximate time) with already "busy" ministers. The following is a breakdown of the current participation by denomination.

Denomination	Letters Mailed	Refusals	Unable to Contact#	Completed Interviews
SDA	19*	1	3	5
Presbyterian	9	0	2	7
Baptist	18	0	4	8

*An SDA minister who declined to participate was the pastor of two churches.
#Ministers either unable to contact or schedule an interview.

Task 4. Analyze Qualitative Data

A. The 20 completed interviews were transcribed as they were acquired. At the time of instrument construction, a set of domains were developed and used to organize and focus the questions in the final in-depth interview guide. The responses were recorded by

domain and item, and denomination to identify consistent themes and highlight items that needed refining for possible inclusion in the Phase 2 mail survey. Based on preliminary reviews of the data, members of the research team who conducted the interviews have constructed items for the Phase 2 mail survey.

B. A summary of the qualitative findings from Phase 1, along with a draft of the Phase 2 mail survey, were reviewed with the steering committee at one of its scheduled meetings. Copies of these documents were mailed beforehand to focus and expedite discussion.

Task 5. Develop Mail Survey

A summary of the findings from Phase I were reported to the Steering Committee at the fall meeting. Comments were provided from each of the ministerial representatives on the content and format of the quantitative survey. In addition to the proposed mail format, it was suggested that participating in ministerial conferences would aid data collection. A draft of the mail survey document was developed and distributed to the research team for review and comment. Multiple revisions were made until the final document was approved for pretesting. Six ministers pretested the instrument for its relevance, format, length, and ease of completion. Only minor revisions were made following the pretesting segment.

Task 6. Conduct Mail Survey

With the help of the Steering Committee ministerial representatives, directories were provided to generate the mailing of the survey packets which included (1) a cover letter from the ministerial representative,(2) instructions for completing the survey, (3) a data information sheet, and (4) an informed consent document. In the case of Baptists, survey packets were prepared and sent to the ministerial representative who, in turn, coordinated the mailings from his executive office. In all other cases, the packets were sent from the PI's office. A follow-up postcard was issued to all groups approximately three weeks after the initial mailing.

As recommended, the PI and the Research Assistant (RA) attended three ministerial conferences to collect data. The Hampton Baptist Ministers Conference took place at Hampton University, Hampton, VA, in June, 2000, the Seventh-day Adventist (SDA) World Conference was held in July in Toronto, Canada and a second SDA black ministerial conference took place at Oakwood College, Huntsville, AL in December, 2000. Since the last report, the following efforts were made to gather additional surveys among the respective denominations.

<u>For Presbyterians</u>:

The P.I. and Research Assistant attended the Caucus of the African American Presbyterian churches that was held in Los Angeles. From this meeting additional surveys were collected as well as contacts made with persons who assisted in gathering additional surveys from pastors not present at the convention. The researchers continued to engage in follow-up phone calls to the pastors who had received mailed surveys but had not responded.

For Baptists:

Research team members attended a local weekly meeting of the denomination and were able to collect additional surveys. The Baptist Steering Committee representative collected survey during a local conference held in Richmond, VA. An additional set of surveys resulted from this process

For Church of God in Christ (COGIC)

Surveys were distributed at a local conference for the Mid-Atlantic area by a designated representative for the research team. This effort yielded very little data. Plans were being developed to attend the national conference in Memphis (held in November 2001), but in assessing the timing of the conference, the cost to send research members, and the prior success rate with the local meeting deterred the study team from making such an effort. A local Maryland meeting was attended by the P.I., Research Assistant and a Steering Committee member but the meeting was attended by a smaller than advised number of people. All in all, the success in collecting data from this denomination was extremely limited.

For Seventh-day Adventists (SDA)

Phone follow-up continued with the SDA churches who had previously been mailed surveys. Because the SDA represented the largest portion of the data set, less effort was concentrated on garnering additional surveys from this denomination.

Preliminary findings from the survey were presented to the Steering Committee in a final meeting on November 15th. At this meeting, Steering Committee provided feedback on a draft mock-up of the materials planned for dissemination during Phase 3 of the study.

Task 7. Analyze Survey Data

The data collection phase of the study was completed. All survey information was entered into a database. The data were cleansed, checked for completeness and consistency, and then recoded to suit the data analysis plan. The data needed for analyses were then transferred into SPSS where univariate, bivariate and multivariate analyses were conducted. The first table presented lists relevant demographic information. The final N for the study was 357. [NOTE: This number is well short of the 800 originally proposed. This issue is discussed in the section regarding Negative and Positive Aspects of the Research.] Numbers were sufficient to allow for tests of significance for the Baptists, Presbyterians and Seventh-day Adventists. For COGIC data, because of the small numbers, they are only represented in the univariate statistics.

Statistical Analyses

A. Descriptive Statistics

Key demographic data on the churches and pastors included in the survey sample are detailed in this section. The data are summarized in two tables (refer to Tables 1 and 2. In Table 1 (see below) data on the churches in the sample is summarized. Looking at the denominational distribution, as noted earlier, COGIC contributed the fewest number of surveys to the overall

study numbers and SDA the largest, followed by the Baptist and Presbyterian respectively. In reviewing regional representation, the Mid-Atlantic and South/Southeast regions comprise the largest percentage of the pastors surveyed (almost 76% combined). With regard to congregation size, most of the pastors had congregations consisting of 250 active members or less (61%), with the next largest category being those with a membership between 251 and 500 (23%).

Table 1. Demographic Characteristics of the Churches

Characteristic	Frequency	Percent
Denomination (n=357)		
Baptist	114	31.9
Presbyterian	97	27.2
Seventh-day Adventist	124	34.7
Church of God in Christ	22	6.2
Region (n=357)		
Mid-Atlantic	90	25.2
South/Southeast	180	50.4
Central	41	11.5
West	19	5.3
Northwest	3	.8
Northeast	3	.8
Other (Carribean & Canada)	21	5.9
Congregational size (n=357)		
250 or less	218	61.1
251-500	82	23.0
501-750	21	5.9
751 or greater	36	10.1

In turning to the pastoral data (refer to Table 2), the first observation is that the vast majority of the sample are male. This was to be expected. The SDA and COGIC do not allow women to be pastors. The Presbyterians have an open policy on female clergy. With the Baptist, depending on the conference affiliation and position of individual congregations, women may or may not be allowed to serve as pastors. Eighty-five percent of the sample are married. Only 2% do not hold a college degree of some kind while the majority of these pastors hold masters and doctorates (approximately 73%). The average age of the pastors is 51. For the males in the study, they represent a key age group for prostate cancer control.

Table 2: Demographics Characteristics of the Pastors

Characteristic	Frequency	Percentage
Gender (n=351)		
Male	333	94.9
Female	18	5.1
Marital (n=350)		
Married	350	85.2
Widowed	9	2.5
Divorced	27	7.0
Separated	5	1.4
Never Married	9	2.5
Education (n=334)		
Less than college	2	2.1
College Degree	65	18.2
Masters Degree	167	46.8
Doctorate Degree	95	26.6
Age (n=340)	Mean	SD
Minimum = 21; Maximum=88	51.19	10.95

The next set of descriptive data provide a picture of the ongoing health programs within the churches overall as well as specific questions asked regarding prostate cancer information. It is important to note that the majority of pastors reported having an existing health ministry within their church (82.1 %).

A summary of some of the prostate cancer specific survey items are reported in Table 3. Pastors were asked about the health programs that had been delivered in their churches in the past 12 months, prostate cancer program was included in that inventory. Less than one-third of the churches had delivered a prostate cancer program in the last 12 months. Only smoking cessation and support group sessions had been delivered less often by the churches (18.8% and 26.9% respectively). Overwhelmingly, pastors indicated that they would like material tailored to their denomination. The pastors were provided a list of prostate cancer information formats. The most frequently endorsed format across all denominations was seminars followed by brochures and then videos. The pastors were less interested in having bulletin notes and receiving mailings. Ranking of preferred formats differed minimally by denomination.

Other prostate cancer-related items in the survey: Findings show that almost 80% of the pastors were very interested in having a prostate cancer program introduced in their churches while only 19.7% were not interested or somewhat interested. The mean level of prostate cancer knowledge among the pastors was 6.2 (SD=2.4) on a scale of 1-10. No apparent denominational differences were noted among these variables. (Refer to Hypothesis 2)

Table 3: Prostate Cancer Related Items

Item	N	Responses in %	
		yes	no
Have you held a prostate cancer program in your church in the last 12 months?	357	30.5	69.5
Are you interested in receiving material tailored to your denomination?	352	90.9	9.1
Would you be interested in receiving prostate cancer information in the form of a brochure?	355	71.0	29.0
Would you be interested in receiving prostate cancer information in the form of a seminar?	355	75.5	24.5
Would you be interested in receiving prostate cancer information in the church bulletin?	355	45.1	54.9
Would you be interested in receiving prostate cancer information in the form of a video?	355	68.7	31.3
Would you be interested in receiving prostate cancer information in the form of mailings?	355	35.5	64.5
Have you, or anyone close to you, had prostate cancer?	351	29.4	70.4

B. Multivariate Analyses

Using logistic regression, we evaluated a set of variables associated with having held a prostate cancer program in the past 12 months (refer to Table 4). Variables included in the model were denomination, belief in church having a role in health, pastor's personal experience with prostate cancer the percentage of men in the congregation, presence of a health ministry with key variables being denomination and church role in health (refer to Hypothesis 1). These variables were included after preliminary bivariate analyses. Results of the analysis indicate that with regard to denominational differences, the Seventh-day Adventist Churches, as reported by the pastors, were significantly more likely to have had a prostate cancer program. No difference was noted between Presbyterians and Seventh-day Adventists. The degree to which the pastor felt that the church has a responsibility to individual's regarding health was not associated with having a prostate cancer program. [Note: SDA was used as the reference category given their denominational commitment to health ministry.] Other significant associations ($p<.05$) to prostate cancer programs were pastoral knowledge of prostate cancer, congregational size and health ministry. Greater knowledge, larger membership, and having a health ministry were associated with a greater probability of having had a prostate cancer program. Percentage of men in the congregations had a weak positive association with having a prostate cancer program.

Table 4: Summary of Logistic Regression (Outcome: Prostate Cancer Program)

Variable	B	S.E.	Odds Ratio	Sig. Level
Baptist vs SDA	.726	.340	2.07	.033
Presbyterian vs SDA	.648	.348	1.91	.063
Church role in health	.421	.292	1.52	.149
Prostate cancer knowledge	.201	.065	1.22	.002
Prostate cancer personal experience	-.143	.310	.67	.645
Percentage of male members	.597	.307	1.82	.051
Presence of a health ministry	1.41	.587	4.10	.000

Intradenominational differences were assessed as well (refer to Hypothesis 3). Findings from these analyses indicate that congregational size is a significant factor in having health ministry and health programs across all denominations (refer to Table 4). We have presented variables with a significance level of $p<.10$. This was done because a larger sample size would have greater power and these variables may have achieved significance at .05. For every model, with the exception of having a health ministry for the SDA, the greater the number of active members, the greater the likelihood of having a health ministry and a prostate cancer program, as well as being associated with higher numbers of health programs.

Within the Baptist denomination: Other than congregational size, only the rating that pastors gave to the importance of health ministry as part of their pastoral duties was significantly associated with health programs, specifically with the number of health programs. None of the other factors included in the models distinguished among the Baptist churches.

Within the Presbyterian denomination: Other than congregational size, pastor's belief in the church having a role in health, marginally the number of years pastors had been serving their church, and the rating of health related duties differentiated churches with regard to health related activities.

Within the SDA denomination: There was the least internal variation within the SDA. Only congregational size was associated with the number of health programs that had been delivered.

Table 5: Summary of Regression Models (variables with alpha levels<.10)

	Baptist	Presbyterian	Seventh Day Adventist
Model 1: Having a Health Ministry			
Church role		OR=4.12 (p=.010)	

Congregation size	OR=2.03 (p=.061)	OR=3.36 (p=.095)	
Years as pastor		OR=1.08 (p=.056)	
Model 2: Number of Health Programs			
Pastor's task rating of health	t=3.38 (p=.001)	t=2.27 (p=.025)	
Congregation size	t=4.56 (p=.000)	t=3.36 (p=.001)	t=5.44 (p=.001)
Percentage of men in congregation			
Model 3: Prostate Cancer Program			
Congregation size	OR=1.65 (p=.016)	OR=2.28 (p=.007)	OR=1.73 (p=.010)
Pastor's education			
Urban/rural setting			

Task 8. Development of Denominationally Tailored Material

The data findings and discussions with the Steering Committee facilitated the development of tailored denominational educational resource packet. From the data reported in Table 3., tailored letters and accompanying prostate cancer control resources were assembled. A"mock" packet is included in the Appendices. The issue of doctrinal difference was not a distinct factor in the formation of the design and development of the resource packet. What emerged as more salient were the types of materials that pastors noted. The team is still trying to identify a suitable (i.e., that focuses more on prevention and informed decision-making and less on treatment for prostate cancer patients) and affordable videotape, which many pastors reported as a their first choice of educational resource product.

Two steering committee members: a former Cancer Information Service coordinator who currently works with cancer outreach for the Oncology Center and one of the two prostate cancer survivors assisted in the selection of appropriate resources for the packet. The prostate fact sheets were also composed with their assistance and all materials were distributed to the entire Steering Committee for their input and feedback. Each packet will bear a label of the respective denomination. A cover letter is addressed to the pastor highlighting the general and denomination-specific findings (listed as one or two bullets), contents of the resource packet, how to use the resources contained in the packet, and a statement of thanks for their time and participation. Recognizing the challenges in collecting data with this population, we have only informally urged the pastors to give us their feedback on their approval and use of the materials. The PI's contact information, including e-mail address to facilitate ease in responding for some, will appear on the inside of the folder. The following educational items are included in the resource packet:

- Booklet: "Understanding Prostate Changes: A Health Guide for All Men." National Institutes of Health, National Cancer Institute.

- Booklet: "What You Need to Know About Prostate Cancer." National Institutes of Health, National Cancer Institute.

- Brochure: "Early Detection. Your Best Defense Against Prostate Cancer."Astra Zeneca.

- Pamphlet: "For Women Who Care: Information on Prostate Disease to Share With the Men in Your Life."

- Booklet: "Down Home Healthy Cooking. Recipes and Healthy Cooking Tips." National Institutes of Health, National Cancer Institute.

- Fact Sheets:
  1. Making African American Men's Health a Priority
  2. Risk Factors for Prostate Cancer
  3. Early Detection/Screening Tests
  4. What You Need to Know When Establishing a Prostate Screening Program
  5. What You Need to Know if you Want to be Screened for Prostate Cancer
  6. Additional Resources/Internet Contacts

II. Positive and Negative Aspects of the Research

As with any research, this project has had both positive and negative aspects, though the positive elements of the work have outweighed its negatives. The negative characteristics of the work are as follows:

NEGATIVES

(1) Among the four denominations, the Church of God in Christ denomination fell far short of the planned numbers. While there was some anticipation of difficulty in partnering with this denomination, the difficulty exceeded expectations. The shortfall reflects two phenomena. One is the historical lack of participation of this denomination with groups outside of its organization. Second, and related to the first, was the representation to the Steering Committee. While we had the consent of the national organization, we were unable to have a pastoral representative on this body but had to rely on a church official. Third, and final, because of the lack of previous encounters, more time was needed to work with this group than as compared with the other three denominations. That being said, a large body of African American men are members of this denomination and future work needs to factor in a time of relationship-building in order that this harder-to-reach faith population.

(2) The other three denominations fell short of projected numbers as well. While these are denominations that have traditionally been more open to other organizations, pastors, much

like doctors, are a group not easily surveyed. The feedback from the pastors, even those who did not participate, points primarily to multiple demands on their time and competing priorities. This was something known in advance and considerable effort was put into recruiting pastors to participate but numbers still did not meet expectation. However, feedback from the pastors on the Steering Committee indicates that the numbers achieved were better than they would have expected. The Presbyterian pastor indicated that we had managed to survey 25% of the African American Presbyterian pastors nationally.

POSITIVES

(1) While the COGIC presence was very limited, a dialogue has begun and interest has been generated within this group. The pastors who did participate in the study all expressed great interest in gaining more prostate cancer information. This initial step provides the beginnings of a relationship that may open the denomination, and consequently its membership, to begin to address the issue of health within their churches. Establishing this initial entré should prove beneficial in fostering a partnership between this faith community and the public health community around prostate cancer as well as other health issues.

(2) The second positive aspect of the research is that the pastors who participated on the Steering Committee functioned as a part of the Research Team. By doing so, the foundation for future university-faith community partnering has been laid. What the pastors conveyed clearly was the concern of many of their fellow pastors that researchers take but do not give back nor consider the needs of the churches. In some measure, this research process spoke to both of those issues and has been conducted in such a way that the researchers can return to these pastors and denominations for further work.

(3) The third positive aspect of the research is that we do have on hand valuable data regarding existing prostate cancer education, desired information, desired formats, level of interest and how these relate to the church's doctrines and church structure. Further, while our numbers were not as large as planned, various regions of the United States are represented in the data set. The analytic section will provide details of the work. Consequently, the information gleaned, once published, should add to the body of evidence available regarding faith-based prostate cancer education, the need for and nature of tailoring programs and materials and may provide some guidance for future research strategies.

KEY RESEARCH ACCOMPLISHMENTS

A. Completion of the data collection phases of the research.

B. Presentation of findings and draft packet to the Steering Committee.

C. Creation of a "Pastor's Guide to Prostate Cancer Screening for African American Congregations" including denominationally-specific summary report, prostate cancer fact sheets, prostate cancer screening guides, series of informational brochures and list of

resources.

D. Formation of a cadre of denominationally diverse clergy who are assisting in the development of research strategies to support faith-based cancer control activities.

REPORTABLE OUTCOMES

A. Training grant awarded by USAMRMC in January, 1999 to the PI on the related topic of "The Assessment of Spirituality as a Function of Quality of Life in Prostate Cancer Patients."

B. Presentation on the topic of religion and coping included discussion of the study and preliminary findings delivered at a lunchtime seminar in the School on August 6, 1999. (Consultant to the study: Dr. Kenneth Pargament, Associate Professor of Psychology at Bowling Green State University and author of the book "The Psychology of Religion and Coping."

C. Abstract submission and acceptance at the American Public Health Association Conference (1999) on a related study of prostate cancer and spirituality. (PI)

D. Presentation on the related topic of religion, health, and women delivered at the Maryland AIDS Administration's Conference on Women's Issues and HIV on October 22, 1998. (PI)

E. Presentation on the topic of urban and community health included discussion of the study delivered at JHU's Black History Month program on February 11, 1999. (PI)

F. Presentation on the study delivered at the National Black Presbyterian Caucus Clergy Conference on April 22-22, 1999. (PI)

G. Presentation on the study delivered at a meeting of researchers at University of Michigan who conduct religiosity and spirituality research. (PI and consultant, Dr. Kenneth Pargament).

H. Preliminary analysis of the data was presented at the Intercultural Cancer Council's 8th Biennial Symposium held in Washington, DC in February 2002. The presentation has been included in the Appendices. (Research Assistant/Postdoc, Dr. Kim Dobson Sydnor)

E. This research has provided the foundation for further studies. The principal investigator has been funded for further research with these four denominations in the area of cancer control. In this next study, researchers will be able to go into churches and work in concert with congregation members to tailor cancer prevention education programs that are consistent with the church context. The details of the study are provided in the Appendices.

F. Manuscripts are forthcoming.

CONCLUSIONS

The intent of the study was to identify denominational differences that would have an influence on tailoring messages in a faith-based model. The initial pilot interviews (Phase I) with the pastors revealed little in the way of doctrinal differences with respect to influence and implementation of faith-based prostate cancer programs. Most pastors believe that the topic is an important one but that a variety of resources are needed to support and sustain these activities. This was the case with the quantitative surveys (Phase II) as well. Consequently, the focus of the research shifted from doctrinal differences to structural factors with potential to inform specification of prostate cancer educational strategies across the participating denominations.

It is clear that this study had a number of obstacles that made conducting the research more difficult than studies that do not include this level of involvement with faith-based organizations. These obstacles do not diminish the relevance of engaging denominations and congregations in health promotion and disease prevention, particularly for African American populations. However, it does require a recognition on the part of researchers and funding agencies that a considerable amount of time and effort, more than is generally expected, is needed. We learned from the pastors that data collection, in and of itself, is an insufficient inducement to participate in public health research; pastors want to partner in research that will provide some immediate benefits to their congregations.

What became overwhelmingly clear is that participatory research with community organizations and/or its members requires considerable time to develop and cultivate authentic partnerships and collaborations and that knowledge of these organizational structures is critical to undertaking the research study.

APPENDICES

The following documents are included in this section:

- List of salaried employees.
- Powerpoint presentation of preliminary data delivered at the Intercultural Cancer Conference in Washington, DC (2002).
- Summary of newly-funded study on "Promoting Cancer Prevention and Control in Baltimore's African American Faith-Based Community" that builds upon the DOD-funded research.
- Education Resource Packet for Pastors (DRAFT)

PERSONNEL RECEIVING SALARY FROM THE RESEARCH

- Janice Bowie, Principal Investigator
- Barbara Curbow, Investigator
- Thomas LaVeist, Investigator
- LaVern Riggs, Secretary
- Matilda Channel, Budget Administrator
- Kim Dobson Sydnor, Research Assistant

Steps toward a Tailored Faith-Based Approach to Prostate Cancer Education

Presented at the
8th Biennial ICC Symposium
Washington, DC
February 7, 2002

by
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in Collaboration with
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Barbara Curbow, PhD
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Funding by the Department of Defense Prostate Cancer Research Program

The Steering Committee

Denominational Representatives
- Ms. Audrey Byrd (Church of God in Christ)
- Dr. Curtis Jones (Presbyterian)
- Dr. DeWitt Williams (Seventh-Day Adventist)
- Rev. Cessar Scott (Baptist)

Cancer Consultants
- Ms. Donna Cox
- Dr. Michael Gibbons
- Col. James Williams (Ret.)

Background and Significance

- Prostate cancer disproportionately impacts African American men (60% higher incidence rate for blacks vs whites - NCHS, 1997)
- Disparity in rates of morbidity and mortality demand focused attention on the problem.
- Churches have been identified as a mechanism for delivering prostate cancer messages.
- Literature indicates little account has been taken of the variations between churches, specifically denominational, which may influence program implementation and success.

Methods

Phase 1:
- Phone and face-to-face interviews of 20 pastors from three denominations
- Feedback from Phase I used to develop as well as include/exclude items for inclusion in the broader study

Denominational Breakdown

Seventh Day Adventists	25% (5)
Baptists	40% (8)
Presbyterians	35% (7)

Methods (cont)

Phase 2:
- Survey developed and administered (30 item survey)
  - church and pastoral demographics
  - church health ministry leadership
  - church resource needs relative to health programs
  - denominational beliefs
  - prostate cancer specific information (e.g., program interest, personal experience, desired materials)
- Data collected via mail, phone follow-up and conference attendance (local and national)

Overview

- Demographics
- Current Status of Church-based Health Programs
- Assessment of Need
- Exploring Denominational Beliefs
- Prostate Cancer Specific Information
- Summary and Discussion

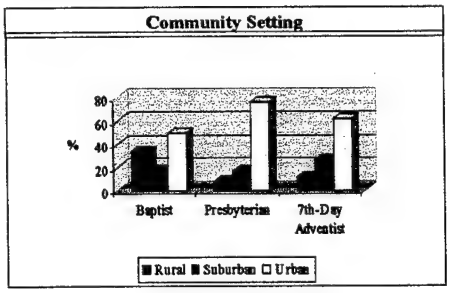
❶ Demographic Data

Demographic 1

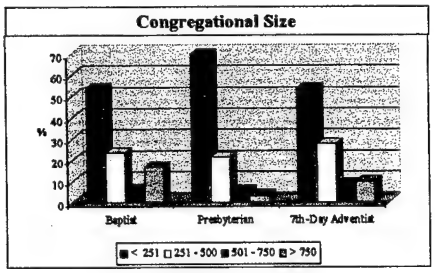
Participants

- 338 pastors/pastoral representatives
  - 115 Baptists
  - 93 Presbyterians
  - 130 Seventh-Day Adventists
- 33 US states plus Canada and the West Indies (all outside US are Seventh-Day Adventist)

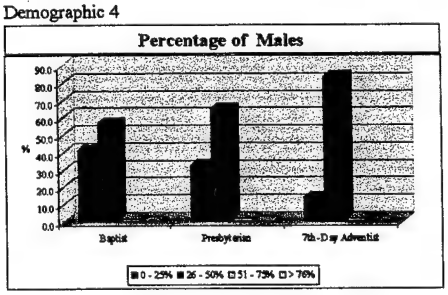
Demographic 2



Demographic 3



Demographic 4



Current Status of Church-based Programs

Current Status 1

Health Ministry Leadership Formats

	Baptist % (n)	Presbyterian % (n)	7th-Day Adventist % (n)
Pastor/clergy	16.0 (17)	14.3 (13)	12.4 (16)
One lay member	12.3 (13)	15.4 (14)	32.6 (42)
Group of lay members	18.9 (20)	19.8 (18)	35.7 (46)
Outside organization	4.7 (5)	2.2 (2)	1.6 (2)
Other	30.2 (32)	22.0 (20)	16.3 (21)
No health ministry	17.9 (19)	26.4 (24)	1.6 (2)
N=	100(106)	100(91)	100(129)

N= 106/115; N= 91/93; N= 129/130

Current Status 2

Who Delivers Health Messages/What Settings?

Setting of delivery	Baptist % (n)	Presbyterian % (n)	7th-Day Adventist % (n)
Via the sermon	71.3 (82)	57.0 (53)	77.7 (101)
In front of congregation	30.4 (35)	18.3 (17)	55.4 (72)
Pastor in small groups	53.9 (62)	34.4 (32)	51.2 (66)
Others in small groups	67.8 (78)	66.7 (62)	67.7 (88)
Not discussed (Pastor)	4.3 (5)	7.5 (7)	1.5 (2)
Not discussed (Others)	2.6 (3)	2.2 (2)	.8 (1)

Current Status 3

Health Programs in the Past Year

(last 12 mths)	Baptist % (n)	Presbyterian % (n)	7th-Day Adventist % (n)
Have had some type of health program	79.1 (91)	88.2 (82)	94.6 (123)
No health program	20.9 (24)	11.8 (11)	5.4 (7)
N=	100 (115)	100 (93)	100 (130)

❸ Assessment of Need

Needed Resources to Add Programs

	Ranking (%) – Top 5		
Resource	Baptist	Presbyterian	7th-Day Adventist
Manpower(in-church)	# 4 (49%)	# 2 (63%)*	# 3 (53%)*
Expert (outside)	# 1 (64%)	# 1 (65%)	# 2 (54%)
Administrative Help	# 5 (44%)	# 5 (48%)	-
Relevant Information	# 2 (59%)	# 2 (63%)*	# 3 (53%)*
Money	# 3 (51%)	# 4 (62%)	# 1 (57%)
Congregation support	-	-	# 5 (27%)

* indicates tied ranking – ranking shared and next ranking is eliminated

Denominational Beliefs 1

Key Church Teachings (checklist results)

- three items - health promotion, healing, and social gospel
- differences found only for health promotion
- Seventh-Day Adventist more likely to have endorsed this item (81% vs 47% Baptist vs 57% Presbyterian)

Rating of Health Promotion

- pastors asked to rate importance of health promotion
- Seventh-Day Adventist placed (on average) greater importance than did Baptist and Presbyterian

Denominational Beliefs 2

Responsibility for Health

Sickness is:	*Role in individual health*
(a) God's will?	(d) **the Church?**
(b)God's permissive will?	(e) God?
(c) related to sin?	(f) the individual?

	Percent Strongly Agreeing		
	Baptist	Presbyterian	7th Day Adventist
(a)	3%	0%	< 1%
(b)	39%	9%	28%
(c)	51%	28%	61%
(d)	69%	59%	79%
(e)	77%	70%	85%
(f)	87%	85%	93%

❺ Prostate Cancer Specific Information

Prostate Cancer 1

Prostate Cancer Knowledge

- There was no significant difference in the average level of knowledge across the denominations
- On a scale of 1 - 10 the average score was 6.28 (SD=2.34)

Personal Experience with Prostate Cancer

- Baptist had the highest percentage (43%) of pastors who had personal experience with prostate cancer (self or immediate family)
- Seventh-Day Adventist and Presbyterian had lower and similar numbers (24% and 26% respectively)

Prostate Cancer 2

Denominationally Tailored Material

- All denominations expressed high level of interest (>75%)
- Seventh-Day Adventist and Baptist expressed greatest interest (97% and 93% respectively)

Interest in Adding a Prostate Cancer Program

- Fairly equal level of interest across all three denominations
- Percent who were very interested ranged from 74% (SDA) to 89% (Presbyterian)
- A very small segment expressed no interest in adding a program (range of 0% for SDA to 2.6% for Baptist)

Prostate Cancer 3

Effective Ways of Presenting Information on Prostate Cancer Screening

	Ranking (%)		
	Baptist	Presbyterian	7th-Day Adventist
Presentation format			
Seminar	# 1 (81%)	# 3 (66%)	# 1 (82%)
Brochure	# 2 (73%)	# 1 (77%)	# 3 (65%)
Video	# 3 (71%)	# 2 (67%)	# 2 (75%)
Bulletin	# 4 (50%)	# 4 (48%)	# 4 (40%)
Mailing	# 5 (43%)	# 5 (33%)	# 5 (34%)
Internet/CD ROM	# 6 (17%)	# 6 (26%)	# 6 (22%)

Summary and Discussion

- Greater appreciation of the commitment involved in pairing/partnering with churches
- among African American pastors/church leaders (across the three denominations) there is a high level of common ground
- differences are apparent in the breadth of existing programs; formats for presentation of prostate cancer information; infrastructure for health education;
- most compelling - the interest in prostate cancer across all denominations

SUMMARY

Promoting Cancer Prevention and Control in Baltimore's African American Faith-Based Community

I. Background and Significance

There is a disproportionate burden of cancer borne by African Americans across a variety of cancers. While considerable effort has been placed, the gap between African Americans and whites remain. In Maryland, four cancers are largely responsible for the high incidence and mortality rates among African American adults: breast, prostate, lung, and colorectal. The majority of these cancers occurred in Baltimore, where the population is 65% African American. A host of social and economic factors act as barriers to earlier detection and diagnosis of cancer in minority Baltimore residents suggesting that strategies for addressing the disparities may need to involve more than the traditional routes of health and patient education. The inclusion of social and cultural factors could lead to the delivery of more appropriate services and tailored messages.

There are several hundred predominantly black churches in metropolitan Baltimore and quite a few have been avenues for high blood pressure and other categorical health programs. Yet, there remains a high level of unmet need among Baltimore's African American community in seeking health care and participating in prevention and early detection of cancer. As congregations are increasingly bombarded with requests for health programming, effective interventions are being requested that take into account strategies that 1) include holistic, rather than, categorical approaches to disease reduction and improved health; 2) ensure complete involvement of clergy and church members; 3) provide a certain level of skill to members of the congregation; 4) frame health issues and messages in ways that stress how to improve health and quality of life rather than mortality statistics; and 5) engender a sense of partnership in the research process.

II. Specific Aims

The specific aims of the proposed research are to:

(1) Employ a faith-based participatory research model to develop a cancer control informed decision-making model within the context of a church-based delivery system using qualitative and quantitative research methods.

(2) Develop multiple culturally-tailored media material to encourage cancer awareness and health promoting behaviors among the congregations within African American churches; cancers being those that disproportionately impact African Americans in Baltimore communities (i.e., breast, prostate, lung, and colorectal).

III. Study Design

The proposed research will take place over a two-year period and will use a combination of quantitative (self-administered survey) and qualitative (Steering Committee discussions, discourses with church congregations) data with the ultimate goal of developing a media materials packet for each denomination investigated.

Phase I: Develop survey instrument using data analysis and feedback from previous research[1] on prostate cancer with clergy from the Baptist, Presbyterian, Seventh Day Adventists

[1] This study examined the role of denominational doctrine and prostate cancer in African American denominations. Over 300 clergy were surveyed about prostate cancer and their health ministries in terms of needs, resources and materials to conduct prostate cancer control programs within their respective churches.

(SDA) and Church of God in Christ (COGIC) denominations, as well as from literature pertinent to the objectives of the proposed study. Pastors (or pastoral representatives) from each of the churches will form the Steering Committee for the study project. Churches will be recruited from the four denominations* using their conference lists as the sampling frame. From each participating church, 20 congregants will be recruited to participate in the church discourse sessions.

Phase II: Combining group discussion and self-administered questionnaires, the 20 congregants per church will be surveyed for their points of view to include knowledge, attitudes and behaviors around the major cancers and the kinds of messages and materials they feel should be developed within the context of church experiences. For each church, the congregational session will be videotaped and audiotaped, led by a facilitator assisted by a notetaker/recorder.

Phase III: The taped discourse will be transcribed and coded for themes associated with the specific aims: decision making in cancer control and materials development for faith-based settings. The survey instrument will be quantitatively analyzed to validate the information obtained in the discussion sessions.

Phase IV: The qualitative findings from the congregational sessions and the results from the quantitative analyses will be used to inform the development of materials for cancer awareness and control. Potential media formats are likely to include video, brochure, fact sheets, newsletters, bulletin insertions, and sermon talking points. The materials will be pre-tested with the ministers as well a subset of the session participants (N=50). Materials will be refined based on the feedback provided by these two groups.

Phase V: The materials developed in Phase IV will be disseminated to each participating congregation for evaluation and feedback. This information will be revised and final products will be made available to all participating denominations.

Phase VI: A final report will be prepared and submitted.

Participants

Participants will consist of clergy and adult congregant's ages 18 and older from 20 area churches in four denominational groups: Baptists, SDA, Presbyterians, and Pentecostal. Clergy from each of the 20 participating churches will be invited to join the study's steering committee. Churches will be recruited from the four denominations using their conference lists as the sampling frame. A maximum of 400 participants, 20 per church, will participate in the church discourse sessions, which will include group discussion and self-administered questionnaires (Implementation in Phase II.). A maximum of 50 clergy and congregants will pre-test drafts of developed educational materials (Implementation in Phase IV.).

IV. Timeframe

Phase I: Interface with the faith community and develop survey instruments	**(3-4 months)**
Phase II: Conduct congregational surveys	**(3-5 months)**
Phase III: Data analysis	**(3-4 months)**
Phase IV: Develop and pretest tailored educational materials	**(5-7 months)**
Phase V: Evaluate & gain feedback on materials thru congregational surveys	**(2 months)**
Phase VI: Write and submit final report	**(2 months)**

JOHNS HOPKINS
UNIVERSITY

Bloomberg School of Public Health
Department of Health Policy and Management
624 N. Broadway
Baltimore MD 21205-1999

Dear Pastor

It has been our privilege to work with your denomination to bring you this educational packet on prostate cancer. Prostate cancer is a serious public health problem. The evidence shows that it carries a greater risk of death for African American men than it does for any other racial or ethnic group. For that reason, public health researchers are making a special effort to reach Black men. Knowing that one of the key places where we can make contact with Black men is in church, we developed this research project focusing on African American churches.

This educational packet is the culmination of two years of work with your denomination as well as with Seventh-day Adventist, Baptist and Church of God in Christ. Here are a few brief comments about what we learned:

For all denominations:

- There is a high degree of shared experience and thinking about health.
- There is a great interest in getting information on prostate cancer and having a prostate cancer program within the churches.

For Seventh-day Adventists:

- Health ministry is well integrated within the church program.
- The surveyed pastors had a preference for seminars and video as a means of accessing prostate cancer information.

It is our sincere desire that the information contained in this packet will assist you in getting the word out about prostate cancer to your congregation. More importantly, we hope that this will facilitate your process of bringing the message about prostate cancer in a manner that allows you a high degree of control. To that end, we have included in the packet the following:

- A Pastor's Guide to prostate cancer
- A set of Prostate Cancer Fact Sheets
- Complementary pamphlets
- A list of additional resources

Recognizing that your time is limited, we can't stress enough the importance of your role in getting across the message of promoting prostate cancer awareness. With your help in educating African American men about this disease, more lives may be saved.

We have created this material to be easily used by anyone in your congregation. We have a commitment, as public health professionals, to decrease the heavy toll on African American men that comes with prostate cancer. We remain available to assist you in achieving your desired goals for prostate cancer education. We would greatly appreciate your feedback on the material as well as any other comments you might wish to share. Our contact information is listed on the back of this portfolio.

Thank you for sharing your time and input in this research. We look forward to partnering with the churches on future projects aimed at improving the health of African Americans and other minorities.

Sincerely,

Janice V. Bowie, Ph.D., M.P.H.
Principal Investigator

Enclosures

MAKING AFRICAN AMERICAN MEN'S HEALTH A PRIORITY

What do we know?

- ❑ African-American men bear a disease burden greater than their numbers in the population would predict – across almost all diseases
- ❑ African-American men are less likely to make a visit to the doctor.
- ❑ Many of the diseases that kill African-American men are preventable (see Top 10 below).
- ❑ African-American men are essential to the current well-being and future of the African American population.

Top Ten Causes of Death for African American Males
National Center for Health Statistics (NCHS) 2001 data

1. Heart diseases
2. Cancer (all types)
3. Unintended injury
4. Cerebrovascular disease,
5. Homicide
6. HIV/AIDS
7. Diabetes mellitus
8. Chronic lower respiratory disease
9. Kidney diseases
10. Diseases originating perinatally

Information source: *Closing the Gap (*Sep/Oct 2001), - Newsletter of the Office of Minority Health

Given these facts, it is clear that there needs to be a commitment to improving the health and well-being of Black men. Health organizations, social institutions, communities and individuals can all play a part in making that change happen.

As part of that change process, this guide to prostate cancer for pastors of African American congregations has been developed. Prostate cancer is one of the diseases for which Black men have a greater risk of dying. This booklet comes out of the collaborative efforts of Hopkins researchers and pastors from four denominations. Help to make the health of African-American men a priority. Make use of the information contained in this pamphlet. Share it with others.

RISK FACTORS FOR PROSTATE CANCER

What's a risk factor?
A risk factor is anything that increases your chance of developing a disease such as cancer. Different cancers have different risk factors. We give a list of risk factors for prostate cancer in this booklet. However, having one or more risk factors for any cancer does not mean that you will get the disease. Many people with one or more risk factors never develop cancer, while others with no known risk factors have the disease.

Why would I need to know about risk factors?
You need to know about risk factors for two reasons. One is so that you can work on changing any unhealthy behaviors that are associated with the disease, like your eating habits. Two is so you can choose to have early detection tests. This is important because cancers caught earlier are more treatable.

Listed below are risk factors doctors have found increase the chance of men developing prostate cancer.

AGE

The chance of having prostate cancer increases rapidly after age 50. More than 70% of all prostate cancers are diagnosed in men over the age of 65. If you are 70 years old, your chance of having prostate cancer is 12 times that of a 50-year old.

RACE

Prostate cancer occurs almost 7 out of 10 times more often in African-American men as it does in white American men. African-American men are twice as likely to die of prostate cancer as white men.

DIET

Men who eat a lot of fat in their diet have a greater chance of developing prostate cancer. Men with a high-fat diet also tend to eat fewer fruits and vegetables and more dairy products.

FAMILY HISTORY

Prostate cancer seems to run in some families, suggesting an inherited or genetic factor. Having a father or brother with prostate cancer doubles a man's risk of developing this disease. The risk is even higher for men with several affected relatives, particularly if their relatives were young at the time of diagnosis.

Know these risk factors. Use the information to your advantage. Protect your health – it's a gift not a given.

EARLY DETECTION / SCREENING TESTS

Who should be screened/when to screen?

- ❑ All men at high risk (based on risk factor list) should consider annual screening tests for prostate cancer starting at age 45.
- ❑ African American men are in the high risk category and so should start screening at age 45.
- ❑ All other men should consider annual testing at age 50.
- ❑ Annual testing is the best way to find prostate cancer early, which may help save your life.

What is screening?

- ❑ Screening for cancer (also called early detection) is an examination or medical test to find early signs of cancer even if the person has no symptoms.
- ❑ The two screening tests for prostate cancer are the *Digital Rectal Examination (DRE)* and the *Prostate-Specific Antigen (PSA) blood test.*
- ❑ PROSTATE CANCER SCREENING SHOULD ALWAYS INCLUDE BOTH TESTS.

What is a Digital Rectal Examination (DRE)?
Exam performed by a doctor to check for irregularities of the prostate gland by feeling the gland through the rectum. The DRE only takes a few seconds to perform.

What is a Prostate Specific Antigen Test (PSA)?
A simple blood test that checks for the presence of prostate specific antigens. A sample of your blood is taken and then sent to a lab for testing. When this is done, you should ask your doctor or health professional for a copy of the results. The doctor will help you understand your PSA number.
(Note: An antigen is the body's response to particles that do not belong in the blood.)

Follow-up Testing

- ► If the result of the PSA blood test and/or the rectal exam is abnormal, your doctor or health care professional may recommend a follow-up PSA test and/or a biopsy.
- ► Testing and biopsy will find most cancers. A biopsy is usually recommended to make a sure diagnosis.
- ► If prostate cancer is found early, there are many treatment options that enable a man to continue living a normal life.

WHAT YOU NEED TO KNOW
WHEN ESTABLISHING A PROSTATE SCREENING PROGRAM

This sheet contains information that clergy or clergy-appointed staff should consider when planning to conduct or participate in a prostate cancer screening program. Please be sure to raise these issues with any groups that may want to conduct screening activities in your church.

- ❑ Insist that an educational component be offered prior to the screening program. Men need to understand the facts about prostate cancer (including risks, screening tests, follow-up).
- ❑ Ask what prostate cancer screening tests are being offered. Screening should always include the digital rectal exam (DRE) and the prostate specific antigen (PSA) test.
- ❑ Ask for references. Organizations who want to screen should have a good reputation in your community.
- ❑ Negotiate all final agreements in writing. As with any contract or agreement, read carefully and understand fully what is contained in the agreement.
- ❑ Request that all participants sign an informed consent document. This document should state the procedures, tell what will be done with any information collected and include a discussion of the privacy of your information. A signed form indicates voluntary participation.
- ❑ Ask who will conduct the screening tests, where the lab results will be sent and how participants will be notified of the results.
- ❑ Ask if any plans are in place to take care of men who have positive test results and need follow-up care.
- ❑ Ask what will be done with extra blood if more than one blood sample is requested. *Why is this important?* Some programs collect extra blood for later medical uses such as genetic testing and DNA sampling. Participants have a right to know this.
- ❑ Ask if a medical professional will be on hand for counseling or to answer other health-related questions.
- ❑ Talk with prostate cancer survivors from your congregation when planning educational and screening programs. These men and their families know firsthand the experience of living with prostate cancer.

WHAT YOU NEED TO KNOW
IF YOU WANT TO BE SCREENED FOR PROSTATE CANCER

This Fact Sheet lists important points that every man should consider and discuss with a health care professional before deciding to take part in prostate cancer screening.

Be sure to ask these questions in a doctor's office as well as when participating in a health fair or some other community screening program.

- ❑ Ask if the screening test includes both the Digital Rectal Examination (DRE) and the Prostate-Specific Antigen (PSA) blood test. Screening for prostate cancer should always include these two tests.
- ❑ Ask your doctor or health professional about the pluses and the minuses of *you* being screened for prostate cancer including the seriousness of the disease. (For example, discuss your family history, eating habits, provide your age.)
- ❑ Ask *how*, *by whom* and *when* you will be notified of your test results.
- ❑ Ask if your lab test results and medical records will be kept confidential. Also find out if anyone else will be able to get your information and what will be done with your information in the future.
- ❑ Ask what will be done with extra blood samples if more than one is taken. It is your right to know and to decide if you want to give permission for use of your blood other than for the PSA test.
- ❑ Make sure that you read carefully and understand fully all documents that you are asked to sign.

For those who have a doctor ...

Remember to discuss all health care issues with your doctor and ask questions to find out if you need to be screened for prostate cancer.

For those who do not have a doctor ...

We strongly recommend that you get a personal physician so that you can talk about these important health issues.

Additional Resources

Suggested Brochures

Understanding Prostate Changes: A Health Guide for All Men
National Institutes of Health Publication (NIH) No. 98-4303. Call the Cancer Information Service (CIS) at 1-800-4-CANCER

Understanding Treatment Choices for Prostate Cancer
NIH Publication No.00-4659. Call the CIS at 1-800-4-CANCER

Should I Be Tested For Prostate Cancer
American Cancer Society (ACS) Publication. Call ACS at 1-800-ACS-2345

Telephone Contacts

Cancer Information Service (CIS), a national information and education network provided by the National Cancer Institute. It distributes materials and information to patients, the public and health professionals.
1-800-4-CANCER (1-800-422-6237) TTY: 1-800-332-8615

American Cancer Society provides information and publications to patients, general public and health professionals.
1-800-ACS-2345

Internet Contacts

National Cancer Institute (NCI) web site for news, educational tutorials, and CancerNet . Visit NCI's web site at http://www.nci.gov

American Cancer Society web site for cancer information at http://www.cancer.org

US TOO is an independent network of prostate cancer support groups that help newly diagnosed prostate cancer patients http://www.ustoo.com

National Prostate Cancer Coalition (NPCC) is a new national advocacy organization that is dedicated to eliminating prostate cancer as a serious health concern for men and their families. The organization is made up of prostate cancer survivors, families and support groups. http://www.4npcc.org

National Coalition for Cancer Survivorship is a national, patient-led advocacy organization working on behalf of people with all types of cancer. http://www.cansearch.org

Phoenix 5 is an organization that helps men and their companions overcome issues created by prostate cancer**:** http://www.phoenix5.org

Prostate Pointers web site, created by a prostate cancer survivor, and includes information on all aspects of prostate cancer including treatment, physicians in the field, and bulletin boards for patients http://rattler.cameron.edu/prostate/